Medicaid Industry Jobs Hunter 02/24/20

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Medicaid Jobs Hunter

In this packet….

Director, Enrollment | CareSource

Director, Enrollment

Company Name CareSource Company Location Dayton, OH, US

Posted DatePosted 5 days agoNumber of applicants Be among the first 25 applicants

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Description

Role and Responsibility:

- Manage daily enrollment operations and projects through effective

allocation of resources
- Provide leadership and direction to the Enrollment team to ensure goals and standards of the department, and CareSource, are met
- Responsible for hiring, training, coaching and developing direct reports including completing performance appraisals and disciplinary actions
- Mentor managers, team leads and individual contributors to produce consistent, high quality deliverables
- Challenge the status quo and propose improvements in processes for higher efficiency and effectiveness
- Fully understand enrollment end-to-end processes and be able to comprehend impact of enrollment issues on various departments
- Accountable for quality of outputs and operational efficiency of the team
- Accountable for the member enrollment, financial reconciliation and vendor reconciliations for assigned lines of business
- Accountable for complying with and meeting all regulatory requirements assigned to the enrollment team
- Manage enrollment technology and process analysts and associated activities involving 834 file processes and departmental policies and procedures
- Accountable for all enrollment audit engagements to ensure accurate and timely response. As necessary, develop and implement corrective action plans to address audit results
- Accountable for ensuring that all internal enrollment and external SLAs are met for enrollment exceptions including requests from other departments
- Establish, monitor, and enforce enrollment policies and procedures and internal controls
- Accountable for researching existing and new legislative changes in enrollment requirements and ensure CareSource is compliant
- Perform any other job related instructions as requested

Key Decision Rights

- Utilize key enrollment and reporting experience and knowledge to ensure timely and accurate recording and reporting of enrollment activities, Assess internal controls and make appropriate changes to ensure compliance with MAR, regulatory, and other organization requirements

Cross Functional Interactions

- Strategic conversations with all company departments, executive team and CareSource board of directors

Requirements

Education / Experience:

- Bachelor degree in accounting, finance, healthcare management or related field or equivalent years of work experience is required
- Master of Business Administration (MBA) or other related post-graduate degree is preferred
- Minimum of seven (7) or more years of leadership and management experience is required
- Minimum of five (5) years of business operations or similar experience is required, preferably in a health care environment
- Medicaid managed care, Medicare Advantage, or other healthcare experience is preferred

Required Competencies / Knowledge / Skills

- Extensive knowledge of operational processes, preferably with a healthcare company
- Strong knowledge of compliance, audit and regulatory framework and managing internal and external controls
- Able to create long term strategy for enrollment and develop short/medium term initiatives for implementation
- Ability to manage competing priorities, demands, and timelines through analytical and problem-solving capabilities
- Strong leadership skills and able to direct the work of others including development, motivation and rewarding of staff
- Adept at conducting research into operational issues and conformable with managing crisis-like situations
- Wide degree of creativity and latitude (independent judgment)
- Possesses problem solving, critical listening/thinking skills
- Ability to interact with all levels of management
- Advanced computer skills, including proficiency with Microsoft Office suite; ability to learn new technologies quickly
- Advanced interpersonal, written, and oral communication skills and organization change management skills
- Overall understanding of IT environment is a plus

Licensure / Certification

- None

Accountability

- All enrollment related regulatory and compliance requirements
- All internal and external SLAs for enrollment
- Team development

Working Conditions

- General office environment; may be required to sit or stand for long periods of time
- May be required to travel occasionally

Executive Director of Managed Care Contracting EOGH | Prospect Medical Holdings, Inc.

Source URL: https://www.linkedin.com/jobs/view/1742565908/?eBP=JOB_SEARCH_ORGANIC&recommendedFlavor=SCHOOL_RECRUIT&refId=3334a3b1-206e-4784-9599-7fe8c7f68438&trk=d_flagship3_search_srp_jobs

Executive Director of Managed Care Contracting EOGH

Company Name Prospect Medical Holdings, Inc. Company Location East Orange, NJ, US

Posted DatePosted 4 days agoNumber of applicants Be among the first 25 applicants

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Executive Director, Managed Care Contracting – Prospect Medical Holdings Coordinated Regional Care

The Executive Director, Managed Care is responsible for the oversight of fee-for-service and value-based contracting and their implementation and related activities for Prospect Medical Holdings Coordinated Regional Care (CRC)under the direction of the Vice President of Coordinated Regional Care, Pennsylvania, and New Jersey.

The ED Shall Have Primary Responsibility For

- Oversee fee-for-service and value-based contracting activities for EOGH, oversight of the managed care team, and manage payer contracts and relationships for all network hospitals, physicians and ancillary providers. Oversees negotiation of single case agreements, and communicates effectively with the billing department to ensure agreements are carried out appropriately. Develop payer strategies to ensure an optimal contracting and operational outcome for EOGH providers, advocating on behalf of the EOGH providers as issues, opportunities or disputes arise. Responsible for negotiating contracts with managed care payers on behalf of EOGH providers, including rates, payment methodologies, contract language, value-based and shared /full risk payment programs, following all internal controls for contract review, approval and signature and in alignment with EOGH vision, goals and objectives.
- Develop processes and manage the implementation and ongoing management of completed contracts, including identification and tracking of critical contract and renewal dates, ensuring that proper scanning, recording, and filing of contract documents occurs, oversee dissemination and communication of information to internal constituents and education on new /revised terms. Monitor contract performance regarding financial performance, payment integrity, value-based payment programs, compliance with contract terms and key performance indicators. Monitoring payer activity with respect to network development, product strategies, payment policies, and other relevant market intelligence.
- Oversee payer relationships with a focus on promoting proactive, professional and collaborative relationships, problem resolution and avoidance future of issues whenever possible.
- Promote enhanced use of Rubixis and other available contract management tools to support contract negotiations, revenue recovery, and contract performance, providing support to decision support, finance and budget on managed care issues.
- Ensure EOGH providers and payers comply with all contract provisions, via tracking of performance through a variety of means, including the audit of current performance via claims review, reports, etc.
- Work collaboratively with EOGH management, operating unit departments and support areas such as patient access, central billing offices, and medical management areas to improve functions across departments and with payers.
- Prepare and provide training, materials, and tools for use by EOGH providers and their staff regarding key managed care contract provisions, market trends and opportunities for improvement in support of facility goals and objectives, consistent with the mission and values of EOGH. Proactively communicate and educate EOGH operational areas regarding contract changes, policy updates, etc., to ensure EOGH staff have the information needed to successfully implement and operationalize agreements.
- Perform other duties as assigned/required by supervisor.

Candidates Must Possess The Following Qualifications

- Master's degree in a related field with a minimum of 5 years of managed care contracting for multihospital system and reimbursement analysis in either a provider or payer setting required;. Excellent written and verbal communication skills required
- Extensive knowledge, experience and expertise in managed care contracting negotiations, language, modeling analytics, reimbursement methodologies for hospitals, physicians and ancillary providers, shared shavings and risk contracting, managed care regulations and quality/shared savings program metrics and methodologies.
- Excellent skills in Microsoft Office Excel (including advanced spreadsheet and formula manipulation), as well as in Word and PowerPoint. Access skills preferred but not required.
- Demonstrated skills in attention to detail, superior project management, implementation, and analytical ability as well as the ability to coordinate and lead activities using a collaborative and team approach.
- Ability to handle multiple projects and perform independently under tight deadlines with a focus on effective implementation, clear and consistent communication and follow-up.

Lead, HEDIS Operations and Compliance | Humana

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Lead, HEDIS Operations and Compliance

Company Name Humana Company Location Louisville, KY, US

Posted DatePosted 4 days agoNumber of applicants Be among the first 25 applicants

Description

The HEDIS Lead, Operations and Compliance understands end-to-end master data processes and flows and uses that knowledge to design and implement master data management solutions. The HEDIS Lead, Operations and Compliance works on problems of diverse scope and complexity ranging from moderate to substantial.

Responsibilities

Responsibilities

The Lead, HEDIS Operations and Complianceis accountable for ensuring completion of the HEDIS program and regulatory requirements, including: State and Federal regulatory requirements, NCQA requirements, internal and external audits and reviews, oversight of Medicaid implementation activities, and process development and enhancement. The Lead, Data Quality/Integrity champions a collaborative environment with the team and connected partners to determine appropriate strategies for compliance with and completion of regulatory and NCQA requirements, process enhancements, existing Medicaid operations, Medicaid expansion and implementation activities, compliance activities, and process improvement. This position requires demonstration of a high level of professionalism and business acumen as well as cultivating and maturing partnerships within the enterprise. Through individual and team contributions, the Lead, HEDIS Operations and Compliance is responsible for the following:

- Internal and external partnerships to coordinate, direct and oversee Medicaid implementation activities, including: tracking of Medicaid requirements and activities; development of state-specific project plans to ensure all operational activities are accounted for and tracked; and development of metrics and reporting
- In-depth analysis of RFPs, state Medicaid contracts and state measure specifications to identify HEDIS applicable requirements and HEDIS impacts
- Interpretation of regulatory requirements for QSI processes, partnering to ensure applicable data/process updates; and providing insights, impacts and guidance to the enterprise
- Facilitating engagements with Internal Audit, Law, and Enterprise

Risk and Compliance teams, including: leading and preparing QSI teams for audit and assessments participation, ensuring appropriate responses to audits and regulatory inquiries, and ensuring issues are resolved and remediated
- Development, tracking and presentation of HEDIS compliance activities and reporting, including identifying and mitigating risks, and development of controls and mitigation plans
- Identify opportunities across HEDIS processes to ensure compliance and audit requirements are satisfied, while driving process improvement
- Lead the annual review and updates of QSI process documentation, collaborating within QSI for completion, efficiency and simplification

Required Qualifications

- Bachelor's degree
- 3 years experience in healthcare, insurance, or related industry
- Strong consultative and collaborative skills working with a variety of teams and internal/external partners
- Strong analytical skills and experience with large, complicated datasets
- Self-motivated, proactive, highly organized, and demonstrated critical thinking skills
- Excellent communication skills (written and verbal)
- Ability to manage and oversee a wide array of in-flight efforts and effectively absorb and communicate with partners
- Ability to work in ambiguous, fast-paced environment
- Proficiency in Microsoft Office applications, including Word, Excel, PowerPoint and Visio
- Travel - 10%

Preferred Qualifications

- Experience in regulatory compliance and risk identification
- Experience in HEDIS measures and reporting and/or Medicaid implementations
- Experience working with cross-functional teams to implement regulatory requirements and respond to audits and regulatory inquiries
- Background in metrics/KPI development and management

Additional Information

This position is located at the Humana Tower in Louisville, Kentucky

Scheduled Weekly Hours

40

Director, Managed Care | Jobs Interviewing Now from MJH

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Jobs Interviewing Now from MJH

Job ID: 1198966

Employment Status: Full-Time

More Information

Boone Hospital Center is a 394-bed full service hospital located in Columbia, MO. It is a regional referral center located in the center of the state. The hospital provides progressive healthcare programs, services, and technology to people in 26 mid-Missouri counties. Although the hospital is full service, areas in which Boone Hospital Center excels are cardiology, neurology, oncology, surgical, obstetrical services, and numerous other specialties. The hospital maintains a 24-hour emergency center with hospital-based ambulance service and a helipad for incoming emergency air transportation. Recognizing its excellence in nursing care, Boone Hospital Center has been certified as a "Magnet Hospital" by the American Nurses Credentialing Center.

Overview

Role Purpose

In conjunction with the Vice President, Managed Care, execute the payer contracting strategy which has been designed to optimize clinical, financial and operational performance by BJC HealthCare. Direct day-to-day departmental operations that support BJC wide initiatives, including value based contracting strategies, by collaborating with HSOs, Center for Clinical Excellence (CCE), BJC

Medical Group (BJCMG) and Revenue Cycle Management (RCM).Collaborate with internal and external partners on managed care issues to ensure that BJC continues to be recognized nationally as a leader in the healthcare industry.

Responsibilities

- Manages individual(s) including but not limited to: hires, trains, assigns work, manages & evaluates performance, conducts professional development plans. Ensures that the productivity and actions of that group meet/support the overall operational goals of the department as established by department leadership.
- Develop and execute Managed Care strategies that preserve and enhance BJC's financial viability, promote growth and create broad access to BJC Affiliates. Collaborate with system leaders to prioritize and execute strategies. Provide financial analyses to support strategic initiatives and leverage resources.
- Responsible for overseeing the strategic planning, successful negotiation, execution and monitoring of performance for all BJC managed care contracts, including pricing strategies, methodologies, alternate payment models and favorable contract language protections. Lead all aspects of contract negotiations with the health plans from the start through successful completion of the Agreement. Review and develop contract language that protects revenue and improves administrative functions. Direct financial analyses to support contract negotiations including developing the financial strategy and targets, setting the time line for the negotiations, overseeing the development of the financial model and rate proposals, and communicating to leadership. Collaborate with the Center for Clinical Excellence (CCE), Hospitals Service Organizations (HSOs) and BJC Medical Group leaders around pay for performance/shared savings arrangements, including developing metrics, targets and performance reports. Collaborate with the HSO's finance departments to identify opportunities for improvement around contract rates and methodologies to meet their operating margin needs. Ensure that contracts are loaded timely and accurately in the contract modeling system to ensure correct payment of services.
- Provide support for BJC wide initiatives around value based contract models, including executing contracts, providing data analytic and financial support and participating on system focused committees. Oversee the development of report packages that support for various value based arrangements. Responsible for the accurate and timely reconciliation process for CMS bundles, ensuring that the correct gain share payouts are distributed to the appropriate individuals. Provide analytical and reporting support for the pay for performance/shared savings programs in order to monitor performance and improve outcomes.
- Continuously monitor the competitive environment to understand managed care trends impacting current and future healthcare

business and reimbursement models in order to identify opportunities around payer activities, payment policies and product development. Establish network of relationships with other providers, payers, and national organizations in order to create a sharing and learning environment.
- BJC has determined this is a safety-sensitive position. The ability to work in a constant state of alertness and in a safe manner is an essential function of this job.

Minimum Requirements

Degree

- Bachelor's Degree
  - Accounting/Finance/related

Experience
- 2-5 years

Supervisor Experience
- 2-5 years

Preferred Requirements And Additional Job Information

Degree
- Master's Degree

Licenses & Certifications
- CPA

Benefits Statement

Note: not all benefits apply to all openings
- Comprehensive medical, dental, life insurance, and disability plan options
- Pension Plan*/403(b) Plan
- 401(k) plan
- Tuition Assistance
- Health Care and Dependent Care Reimbursement Accounts
- On-Site Fitness Center (depending on location)
- Paid Time Off Program for vacation, holiday and sick time
- Pension does not apply to Memorial Hospital, Memorial Hospital East, Memorial Medical Group, Alton Memorial or Parkland Health Center

Legal Statement

The above information on this description has been designed to indicate the general nature and level of work performed by

employees in this position. It is not designed to contain or be interpreted as an exhaustive list of all responsibilities, duties and qualifications required of employees assigned to this job.

Equal Opportunity Employer

Director of Provider Relations | Neighborhood Health Plan of Rhode Island

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Neighborhood Health Plan of Rhode Island

Overview

The Director of Provider Relations is responsible for the end-to-end oversight, maintenance and satisfaction of the organization's provider networks by developing, implementing and overseeing initiatives in support of strategic, corporate and departmental goals. This highly visible position acts as a liaison between the organization and its provider network by cultivating, maintaining and strengthening relationships, while bringing issues to fair and expeditious resolution. This position ensures that organizational resources for addressing issues are efficiently and effectively utilized, and explores and recommends options for improvement/enhancement. This position further acts as an impartial liaison between the organization and its Federally Qualified Health Centers (FQHC), in order to address issues raised by FQHC executive staff, leadership and providers. This position will seek to achieve a fair and expeditious resolution between leaders, providers and Neighborhood staff. This position has the authority to directly engage executive leadership when standard channels are unable to resolve issues. In addition, this position develops, implements and disseminates reporting/dashboards detailing issues being referred, status, and outcomes, as well as recommendations for future improvements.

Responsibilities:

- Liaison for FQHCs and Neighborhood leadership, and advocates for

to resolve FQHC's issues
- Develop and maintain strong professional relationships with the provider network, their key staff and providers, and function as liaison to research and resolve issues and strategic objectives
- Develop, implement and maintain strategies supporting provider satisfaction
- Responsible for maintaining provider network adequacy standards
- Keep leadership and key stakeholders informed of critical provider issues
- Develop and implement educational processes and pro-active solutions for payment and other provider operations requirements
- Develop and establish guidelines and measures for each team within provider relation, as well as for the department that align with corporate goals and measures and industry standard service levels
- Develop and manage provider servicing strategies to ensure collaborative relationships with providers are built and sustained
- Direct the planning, development and implementation of ongoing communication programs and initiatives for the provider network
- Ability to work independently/without direct supervision
- Identify patterns of organizational and systematic issues and develop and implement solutions to respond issues
- Work collaboratively with staff at all levels of the organization to resolve issues
- Coordinate escalated issues with appropriate partners at delegated vendors
- Attend Leadership Council, Rhode Island Health Center Association and community meetings, as needed
- Attend FQHC social events, as appropriate
- Manage, direct and mentor staff
- Develop employee performance plans, conduct formal performance appraisals and take appropriate disciplinary action in accordance with organizational policies and procedures
- Responsible for the hiring and training process, including recommendations regarding staff retention, termination and succession planning
- Participate on committees, work groups, and/or process improvement teams to improve provider satisfaction
- Support core functions of the department and assist with the departmental objectives and projects
- Monitor, evaluate and routinely report on the performance of providers against goals and targets
- Identify performance issues including policy and procedures, processes, workflows, communication and trends and recommend and implement strategies to address deficiencies
- Ensure timely and accurate submission of required regulatory reports to federal and state agencies and other regulators
- Collaborate and consult with internal leaders and departments to coordinate relevant cross functional activities in support of network performance management efforts to maximize the organization's competitive position
- Assist in the development of operating and capital budget for the

department
- Represent the organization in internal and external committees and meetings
- Prioritize and organize all work to meet deadlines
- Responsible for complying with Neighborhood's Corporate Compliance Program, Standards of Business Conduct, applicable contracts, laws, rules and regulations, policies and procedures as it applies to individual job duties, the department, and the Company. This position must exercise due diligence to prevent, detect and report unlawful and/or unethical conduct by fellow co-workers, professional affiliates and/or agents.
- Corporate Compliance Responsibility - As an essential function, responsible for complying with Neighborhood's Corporate Compliance Program, Standards of Business Conduct, applicable contracts, laws, rules and regulations, policies, and procedures as it applies to individual job duties, the department, and the Company. This position must exercise due diligence to prevent, detect, and report unlawful and/or unethical conduct by fellow co-workers, professional affiliates and/or agents.

Qualifications:

Required:

- Bachelor's degree in Health Administration, Business Administration, Public Health, Communications or a related field or an equivalent amount of experience to equate to a degree
- Five (5)+ years' experience with a managed care organization or a health care related organization (HMO; Medicaid, Medicare)
- Five (5)+ years' experience with commercial, Medicaid or Medicare provider relations, communication, policies or related experience
- Five (5)+ years' experience managing staff including ability to lead, motivate, and develop staff, with effective interpersonal and conflict resolution skills
- Experience working with Federally Qualified Health Centers
- Experience working with behavioral health providers in Rhode Island and surrounding areas
- Intermediate to Advanced skills in Microsoft Office (Word, Excel, PowerPoint, Outlook)
- Proven experience of the health care industry and its impact on providers
- Proven experience building relationships to influence and work collaboratively with internal and external partners, including the provider network, business leaders, community leaders and other stakeholders
- Proven knowledge of federal and state Medicaid, commercial and Medicare health insurance regulation, business practices and reimbursement methodologies
- Proven ability to manage data and processes in multiple platforms
- Proven ability to utilize effective advocacy to realize an organization's mission, vision and values

- Proven ability to balance execution of the strategic vision through leadership and delegation with a willingness to dive into details, as required
- Proven knowledge of Accountable Care Organization (ACO) models and/or the Rhode Island Medicaid Accountable Entity program
- Proven ability to deliver results and motivate and mobilize staff to achieve goals
- Understanding of FQHC medical, dental and behavioral health care services; populations; relationships with federal and state government; funding and reimbursement; and risks to the FQHC business model
- Effective problem-solving skills
- Excellent quantitative and analytic skills with ability to synthesize complex information to create and evaluate options
- Excellent interpersonal skills (including oral, written and verbal) to interact effectively with a diverse range of internal and external constituents, stakeholders, and audiences; work effectively across all levels of the organization; at a high level of diplomacy to anticipate, recognize and address effectively with politically sensitive issues
- High degree of business and financial acumen to manage external delivery system costs and implement strategies that promote and sustain enrollment growth
- Demonstrated ability to work as a change agent within and amongst different organizations, including willingness to challenge the status quo to implement creative strategies and commitment to outstanding customer service and continuous quality and process improvement
- Ability to manage multiple projects simultaneously
- Resilient, collaborative, flexible, innovative
- Ability to travel including reliable transportation, a valid driver's license and proof of insurance

Preferred:

- Master's degree in Health Care Administration, Business Administration, Communications or Public Health or a related field
- Experience in Project Management
- Experience in Cognos
- Experience in MedInsight
- Experience in SharePoint
- Knowledge of Quality Improvement Processes (e.g. Lean, Six Sigma)

FDR Oversight:

Senior Leadership Level:

Assures effective oversight and monitoring of the performance of all applicable First Tier,

Downstream and Related Entities (FDR) so that the services being

provided are consistent with

all contractual and legal requirements as well as company policies and procedures

Flexible Work Arrangement:

- Yes

Telecommuting Arrangement:

- Yes, as per department policy

Travel Expectations:

- Ability to travel including reliable transportation, a valid driver's license and proof of insurance

Neighborhood is an Affirmative Action and Equal Opportunity Employer and all qualified applicants will receive consideration for employment without regard to race, color, religion, gender, sexual orientation, national origin, genetic information, age, disability, veteran status or any other legally protected basis.

Neighborhood is committed to ensuring individuals with disabilities and/or those who have special needs participate in the workforce and are afforded equal opportunity to apply for jobs. If you would like to contact us regarding the accessibility of our Website or need assistance completing the application process, please contact us at recruiting@nhpri.org.

Patient Advocate | Cognizant

Source URL: https://www.linkedin.com/jobs/view/1713922847/?eBP=JOB_SEARCH_ORGANIC&recommendedFlavor=IN_NETWORK&refId=3334a3b1-206e-4784-9599-7fe8c7f68438&trk=d_flagship3_search_srp_jobs

Patient Advocate

Company Name Cognizant Company Location Louisville, KY, US

Posted DatePosted 2 days agoNumber of applicants Be among the first

25 applicants

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Patient Advocate-Full-Time Schedule, 8am-4:30pm, Monday-Friday.

Cognizant Technology Solutions is seeking a Patient Advocate in Louisville, KY.

Job Description

The Patient Advocate will assist clients in person and over the telephone with applications for benefits through Medicaid, Social Security Disability and/or hospital charity program assistance. We ensure that Medicaid, Social Security, County Indigent or other types of eligible funding for health care services is received for patients'. Other duties will be assigned.

Requirements

- High school diploma or equivalent is required
- Degree preferred but not required
- Must have strong computer and typing skills
- Working knowledge of Word and Excel is required
- Experience working with patients on their accounts in a hospital or other health care setting is preferred
- We are seeking professionals who are compassionate about helping those in need.
- Previous experience working with Medicaid and/or in a medical office setting is helpful.
- Must have the ability to maintain and respect confidentiality and HIPAA guidelines
- Must be highly effective in working objectively with a diverse group of people and must demonstrate communication, organizational, administrative and time managerial skills.
- Flexibility is a must in both schedule and job duties.
- Bilingual in English and Spanish is a plus.

Employee Status : Full Time Employee

Shift : Day Job

Job Posting : Feb 21 2020

About Cognizant

Cognizant (Nasdaq-100: CTSH) is one of the world's leading professional services companies, transforming clients' business, operating and technology models for the digital era. Our unique industry-based, consultative approach helps clients envision, build and run more innovative and efficient businesses. Headquartered in the U.S., Cognizant is ranked 193 on the Fortune 500 and is consistently listed among the most admired companies in the world. Learn how Cognizant helps clients lead with digital at www.cognizant.com or follow us @USJobsCognizant.

Cognizant is recognized as a Military Friendly Employer and is a coalition member of the Veteran Jobs Mission. Our Cognizant Veterans Network assists Veterans in building and growing a career at Cognizant that allows them to leverage the leadership, loyalty, integrity, and commitment to excellence instilled in them through participation in military service.

Cognizant is an equal opportunity employer. All qualified applicants will receive consideration for employment without regard to sex, gender, identity, sexual orientation, race, color, religion, national origin, disability, protected veteran status, age, or any other characteristic protected by law.

If you have a disability that requires a reasonable accommodation to search for a job opening or submit an application, please email CareersNA2@cognizant.com with your request and contact information.

Account Director | Sandata Technologie

Source URL: https://www.linkedin.com/jobs/view/1713974067/?eBP=JOB_SEARCH_ORGANIC&recommendedFlavor=IN_NETWORK&refId=3334a3b1-206e-4784-9599-7fe8c7f68438&trk=d_flagship3_search_srp_jobs

(64) Account Director

Sandata Technologies is the leading supplier of technology solutions for the national Homecare industry. Sandata is uniquely positioned as a software technology vendor serving both Payers and Providers in this growing segment of the healthcare market. Sandata's solutions provide a strong Value Proposition for our clients, including compliance, transparency, efficiency, and cost savings. The Sandata solution has been implemented by thousands of homecare agencies nationwide, is leveraged by national MCOs, and has been selected by numerous state Medicaid agencies to ensure their compliance with the federal mandate to implement Electronic Visit Verification (EVV). The company has a national footprint, and is one of the largest technology vendors for the Medicaid homecare industry.

Sandata Technologies is looking for an experienced and energetic Account Director to help support a long-term program to provide Electronic Visit Verification (EVV) services to our client, a large state Medicaid payer.

- The Account Manager will lead Sandata's responsibilities for Outreach and Training work stream during the implementation.
- After program launch, the Account Director:
- Supports the payer client throughout the continuum of their Sandata relationship to ensure the successful achievement of client's business objectives.
- Is responsible for executing the terms of a client's contract and is a liaison to all internal Sandata departments for overall support coordination and problem resolution.
- Is responsible for ensuring client satisfaction with Sandata products and services and building a mutually beneficial partnership relationship.

MINIMUM QUALIFICATIONS:

Education:

- Undergraduate degree in Healthcare, Business Administration or related field
- Master's degree in Business Administration or Healthcare preferred

Work Experience:

- 5+ Account, Implementation, or Project management experience
- 3+ years' experience working with State Health Care agencies or

Managed Care Organizations strongly preferred
- Master's degree in Business Administration, IT, Healthcare or Computer Science preferred

Knowledge/Skills:

Account Management Experience

- Excellent account management skills with an emphasis on advising and consulting clients on maximizing value of company programs while achieving their business objectives
- Demonstrated experience in setting and accomplishing strategic goals for client accounts
- Strong analytical, problem solving skills, and detail orientation
- Previous account management experience

Healthcare Industry Experience

- Experience in large-scale healthcare or state Medicaid program knowledge required
- Understanding of state-based healthcare programs a plus

Software/Technology Experience

- Experience leading or participating in software implementation projects
- Proven ability to work directly with clients and present findings to customers
- Experience responding to client inquiries and support requests

Additional Skills and Experience

- Excellent written and oral communication skills, including experience in creating and delivering formal presentations to large groups and executive teams
- Strong problem solving/data analysis skills
- Strong organization skills with the ability to coordinate multiple tasks/projects and complete within specified time frames
- Collaborative nature, work well in diverse teams, and the ability to work effectively across functional areas of the company from a remote working environment
- Ability to work comfortably in a technical environment, including strong working knowledge of PC-based programs
- Willingness for limited travel as needed

Accountabilities:

- Support the execution of client-specific strategic plan for achieving client business objectives while maximizing client value and revenue to Sandata
- Develop strong working relationships with day-to-day client contact and client management structure
- Day-to-day Sandata resource for Payer client to support communication and deliverables to Payer account

- Facilitate resolution of client issues relating to Sandata products and services
- Provide consistent internal and external communication and timely follow-up on customer issue resolution
- Have working knowledge of government healthcare technology and the claim adjudication process and a thorough understanding of Sandata's products and capabilities
- Provide updates regularly to Sandata management including but not limited to:
- Account status
- Outstanding issues
- Resolutions
- Action plans
- Barriers to client satisfaction with resolution plan
- Conduct analysis regarding program performance, proactively identifying areas to improve program performance and consulting with client accordingly
- Create monthly executive reports and support quarterly/annual reporting as needed
- Identify operational barriers to success and seek to resolve by working with internal and external stakeholders
- Support annual audits, coordinating all necessary resources and developing needed documentation or presentations
- Ensure security of personal health information (PHI) and report any violations or observations to management.

Sandata employees enjoy the following benefits:

- Medical, dental, and vision coverage
- Flexible Spending Account for health and dependent care
- Life insurance
- 401(k) Plan
- Aflac STD, LTD, Critical Illness, Hospital, and Accident insurance
- Employee Assistance Program
- Tuition reimbursement
- Paid vacation and holidays
- Paid lunch break
- Employee discounts and company perks
- Onsite Gym
- Casual work environment
- Frequent employee events and fun social clubs
- Onsite cafeteria with free coffee and tea

Sandata Technologies is an Equal Opportunity
Employer M/F/Disabled/Vet

Integrated Care for Kids (InCK) Model Administrator | Ohio Department of Medicaid

Source URL: https://www.linkedin.com/jobs/view/1745568775/?eBP=NotAvailableFromVoyagerAPI&recommendedFlavor=IN_NETWORK&refId=dba519af-e653-4f9d-aa7e-cb0da9a607bf&trk=d_flagship3_search_srp_jobs

Integrated Care for Kids (InCK) Model Administrator

Company Name Ohio Department of Medicaid Company Location Franklin County, OH, US

Posted DatePosted 5 days agoNumber of applicants Be among the first 25 applicants

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Office: Strategic Initiatives

Classification: Medicaid Health Systems Administrator 3 (PN 20097964)

Job Preview

The Ohio Department of Medicaid (ODM) is seeking an experienced public healthcare administrator to direct, plan and coordinate the development and implementation of the Integrated Care for Kids (InCK) program in Ohio, which will include unique, community-driven targeted interventions to

prevent and reduce out-of-home placements of children. As the InCK Model Administrator, your responsibilities will include:

- directing collaborative efforts with the grant's lead award partner, Nationwide Children's Hospital, and the local community-based Partnership Council
- creating an innovative alternative payment model (APM) that incentivizes InCK's designated outcome metrics
- directing data sharing, collection, and analysis to develop the APM, and evaluating the performance of the InCK model and APM throughout implementation
- coordinating work with the Centers for Medicare and Medicaid Services (CMS) and the CMS Innovation Center to ensure grant requirements are fulfilled and federal authorities are approved
- representing ODM at conferences and seminars related to InCK, and acting as a liaison with ODM personnel, agencies, advocates, and consumers to ensure the successful development and implementation of the InCK model

The preferred candidate will have a demonstrated ability to actively engage and build collaborative working relationships with local and/or county agencies or entities. Also, the preferred candidate will have experience working with accountable care organizations, managing large grants, developing and evaluating alternative payment models and directing large data collection and research projects using Medicaid data.

Job Description

Under general direction plans, directs, and coordinates one unit of professional Medicaid administrative staff in all activities related to one Medicaid health services program (e.g., Integrated Care for Kids (InCK) model of care), including multiple sub-projects related to developing interventions and a pediatric alternative payment model (APM) of Medicaid health care delivery systems that incorporates provider accountability and focuses on meaningful improvements in care quality and health outcomes. Oversees specific projects to: plan novel policy interventions for the InCK model; design and conduct health research projects necessary to develop, implement, and evaluate the pediatric APM, including coordinating data analysis related to payment innovation and value-based purchasing efforts; and develop the Partnership Council, including coordinating ongoing stakeholder relationships and bi-directional communication. Oversees and monitors the department's relationship with the sub-grantees (Nationwide Children's Hospital) related to the InCK model. Acts as agency's expert in overseeing, developing and implementing policies affecting health services related to

pediatric APM(s); directs the InCK team to work with cross-agency teams to ensure appropriate SPA, waiver, and state administrative code are in place for implementation of the APM; leads the InCK team in assisting in drafting/creation of SPAs and/or waivers related to APM implementation; directs work with stakeholders to design the APM(s) to meet the unique characteristics and needs of their target populations; directs the InCK team in cross-agency work to evaluate financial, programmatic, and legal feasibility of emerging approaches; identifies barriers in the current payment system that prevent or impede implementing the improved approach to care delivery; ensures the InCK APM developed prevents duplication with other services and payment models; oversees developing methods for assessing the performance of the APM; recommends new and innovative approaches and directs implements policies on behalf of agency leadership. Supervises assigned staff: makes recommendations for hire; assigns work and provides direction; reviews work and provides feedback; establishes goals and monitors and evaluates performance; encourages staff development; approves/disapproves leave requests; recommends disciplinary action.

Coordinates program policies, procedures and project initiatives with other agency representatives and provides consultation to other office and departmental staff related to the InCK model and its pediatric APM(s); advises deputy director regarding various issues and problems; directs work with CMMI, CMCS, and CMCHO to develop and implement one or multiple child-focused alternative payment models (APMs) adherent to InCK Model requirements; creates and oversees linkages to and coordination with other state and local agency programs and initiatives related to optimum pediatric outcomes; works with stakeholders to: design APM(s) to overcome the barriers in the current payment system and assure the delivery of higher-value care; develop and implement (an) APM(s) that compensates Medicaid providers who serve the attributed population; ensure the design of pediatric APM(s) is supported by appropriate Medicaid and/or CHIP program waiver and/or SPA authorities to pay for these services using Medicaid and CHIP funds; determine how to measure the quality of a beneficiary's care experience in the APM; work with other areas of the agency to ensure necessary Ohio Administrative Code, waivers and state plan amendments are in place through assisting in writing and providing subject matter expertise; draft contract language reflecting managed care plans' participation in InCK model APM implementation; direct with InCK team to work with ODM's office of managed care to ensure the inclusion of contract language reflecting managed care plans' agreement to participate in pediatric APM(s).

Represents agency in conferences, seminars; oversees preparation of statistical and narrative reports related to the InCK model and the pediatric APM(s); Acts as liaison with agency personnel, outside agencies, providers, advocates and consumers; represents agency with outside constituency groups on matters related to the InCK model and pediatric APM(s) or related teamconducted analytical studies; coordinates interaction with state and federal officials with regard to the InCK model and pediatric APM development, structure and evaluation, including participation in regular telephonic conferences with CMS presents research products for use in policy and administrative decision making; directs the InCK project team to ensure that data necessary to demonstrate progress on all operational milestones related to the APM(s) are submitted to CMS or its contracted evaluator; oversees development of a total cost of care measure to evaluate APM return on investment; testifies at legislative or public hearings and/or administrative appeals; originates correspondence; prepares and delivers speeches and presentations; develops and/or assists in developing budget.

Performs other related duties (e.g., conducts and attends staff meetings and training sessions; travels to meeting sites; maintains records, logs and files).

Completion of graduate core program in business, management or public administration, public health, health administration, social or behavioral science or public finance; 36 mos. exp. in planning & administering health services program or health services project management (e.g., health care data analysis, health services contract management, health care market & financial expertise; health services program communication; health services budget development, HMO & hospital rate development, health services eligibility, health services data base analysis).

- Or 12 months experience as a Medicaid Health Systems Administrator 2, 65296.
  Note: education & experience is to be commensurate with approved position description on file.
- Or equivalent of Minimum Class Qualifications for Employment noted above.

Primary Location

United States of America-OHIO-Franklin County

Work Locations

Lazarus 5

Organization

Ohio Department of Medicaid

Classified Indicator

Unclassified

Bargaining Unit / Exempt

Exempt

Schedule

Full-time

Work Hours

8:00AM - 5:00PM

Compensation

$38.47/hour

Unposting Date

Feb 24, 2020, 10:59:00 PM

Job Function

Health Administration

Agency Contact Name

ODM Human Resources

Agency Contact Information

HumanResources@medicaid.ohio.gov

Seniority Level

Entry level

Industry

- Government Administration

Employment Type

Full-time

Job Functions

- Health Care Provider

Director Medicaid | Teva Pharmaceuticals

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Director Medicaid

Company Name Teva Pharmaceuticals
Company Location Parsippany, NJ, US

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Company Info

Teva is a global pharmaceutical leader and the world's largest generic medicines producer, committed to improving health and increasing access to quality health solutions worldwide. Our employees are at the core of our success, with colleagues in over 80 countries delivering the world's largest medicine cabinet to 200 million people every day. We offer a uniquely diverse portfolio of products and solutions for patients and we've built a promising pipeline centered around our core therapeutic areas. We are continually developing patient-centric solutions and significantly growing both our generic and specialty medicines business through investment in research and development, marketing, business development and innovation. This is how we improve health and enable people to live better, healthier lives. Join us on our journey of growth!

Job Description

The Director of Medicaid is responsible for ensuring that each assigned State’s rebate program adheres to all CMS and other applicable requirements. This position ensures that State federal and supplemental rebate programs are actively monitored, that appropriate staffing levels are maintained, training programs for both State and internal Medicaid analysts are accomplished, and the accurate publishing/documenting of communications addressing any changes in guidance for government programs and the Medicaid program that will impact other internal operations. This position drives continuous improvement initiatives and is accountable for all Medicaid rebate budget and financial forecasting. The incumbent will be using Model

N’s Flex program for Medicaid adjudications. This position reports to the Senior Director, Business Finance.

- Work with assigned states to get Medicaid Summary invoice, summary data file and Claim Level Invoice each quarter and review to ensure completeness of information received. Upload data into Model N / Medicaid systems and authorize transactions. Document errors and perform research
- Conduct initial quality check on summary data on all claim submissions to ensure rebate eligibility and data consistency
- Perform Claim Level Detail validation. Review suspect claim records and determines if record should be disputed for payment.
- Resolve disputes and propose recommended amounts to be paid for historical outstanding utilization that is routinely submitted with Medicaid claims. Must have ability to work independently and make recommendation on state disputes, apply proper amounts to be paid & ensure CMS codes are applied correctly; notify states of results/findings.
- Oversees and works in collaboration with the internal rebate managers, and supports the activities and requirements of each specific State Program Director and Account Rebate Manager, appropriate State agency rebate staff, and internal departments supporting the Medicaid FFS rebate team; oversees the State’s drug rebate program
- Represents Medicaid team in meetings with State agency rebate staff as the subject matter expert and coordinates attendance of other rebate subject matter / financial experts as may be needed

Qualifications

- Bachelor’s degree with emphasis in Business, Finance, Accounting or related fields or equivalent combination of education, training and/or direct work related experience.
- 8+ years prior Medicaid Claim processing experience with Pharmaceutical company, state and/or state agency or as Medicaid consultant or equivalent work experience. Prior Supervisory responsibility of staff
- Must have Intermediate to advanced knowledge of the Model N or Revitas/Flex Medicaid and/or Flex Validata system (or other comparable system) and advance Microsoft Excel skills.
- Familiar with CMS Medicaid rules and state specific issues. Up to date knowledge on Medicaid Validation rules and issues with 340B covered entities.
- Strong ability to organize and manipulate large volume of data in various formats. Attention to detail and high degree of accuracy in data processing and reviews.
- Company/Industry Related Knowledge: Medicaid, Government Pricing and Rebate
- Travel Requirements: <10%

Preferred

- Master’s degree
- Pharmaceutical Industry experience; Medicaid Claim processing function; manipulation of large datasets, negotiation/conflict resolution. System Implementation and report writing
- Pharmaceutical industry experience/knowledge

Function

Marketing

Sub Function

Managed Care Administration

Reports To

Senior Director, Business Finance.

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The internal career site is available from your home network as well. If you have trouble accessing your EC account, please contact your local HR/IT partner.

Teva’s Equal Employment Opportunity Commitment

Teva Pharmaceuticals is committed to equal opportunity in employment. It is Teva's global policy that equal employment opportunity be provided without regard to age, race, creed, color, religion, sex, disability, pregnancy, medical condition, sexual orientation, gender identity or expression, ancestry, veteran status, national or ethnic origin or any other legally recognized status entitled

to protection under applicable laws.

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Government Health Care Informatics Senior Data Analyst | Mercer

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(64) Government Health Care Informatics Senior Data Analyst

At Mercer, we make a difference in the lives of more than 110 million people every day by advancing their health, wealth, and careers. We're in the business of creating more secure and rewarding futures for our clients and their employees — whether we're designing affordable health plans, assuring income for retirement or aligning workers with workforce needs.

Mercer is seeking candidates for the following position based in Phoenix, Arizona office:

Government Health Care Informatics Senior Data Analyst

What can you expect?

- *Utilize SAS program to interpret and analyze large health care data sets*
- *Assist in the development of client communications, proposals, reports, spreadsheets and presentations.*
- *Work on multifaceted projects to gain a better understanding of health care delivery systems, specifically government-sponsored health and welfare programs, such as Medicaid and Medicaire*
- *Grow your career by partnering with a supervisor that has similar clients, projects and/or career objectives.*

What is in it for you?

- *Be challenged to deliver impactful solutions for major Government organizations and have a direct imp act on individuals covered by those government programs*
- *Fine tune your natural skills and learn new ones*
- *Opportunity to work with some of the smartest people in the industry, while working for a global company with excellent benefits and a dynamic culture*
- *Participate in a mentorship program with veteran consultants that have years of experience in the consulting industry*
- *Excellent growth, mobility and advancement opportunities*
- *Top benefits – generous PTO including vacation, sick, personal and even one day off for community service!*
- *You will have opportunities to participate in Mercer Cares, our community outreach and volunteerism initiative, which coordinates company volunteer events to encourage employees to give back to our community.*

We will count on you to:

- *Gain an understanding of health care delivery systems, specifically government-sponsored health and welfare programs, such as Medicaid and Medicare*
- *Work in a fast-paced, challenging and dynamic consulting environment with colleagues across all organizational levels to meet and exceed client demands and deadlines*
- *Collaborate with a focused group of colleagues on smaller team based assignments with opportunities to participate in larger scale client and industry projects*

What you need to have:

- *1- 5 years' experience using SAS, SQL or other similar data analytic software*
- *Strong analytical, mathematical, and project management skills*
- *Ability to work both independently and in a dynamic team environment with rapidly changing priorities and demand*
- *Excellent organizational, interpersonal, verbal, and written communication skills*
- *Eagerness to drive results and take initiative*

What makes you stand out:

- *Proficiency using SQL or SAS*
- *Proficiency using Microsoft Excel or similar programs. Knowledge of other Microsoft Office products such as Access or PowerPoint is beneficial*
- *Interest or experience in the health care industry*
- *Strong communication skills and desire to work in a team oriented work environment*

Mercer's Government Human Services Consulting (GHSC) practice focuses on the unique and challenging needs of the public health care sector, providing a wide array of consulting services to local, state, and federal government agencies across the country. GHSC specializes in assisting government-sponsored health care programs in becoming more efficient purchasers of health services and with navigating the evolving landscape of public health care from a regulatory, operational and implementation perspective.

GHSC brings together a team of over 250 highly skilled and dedicated consultants, clinicians, actuaries, analysts, and pharmacists across four offices in Phoenix, Minneapolis, Atlanta and Washington DC to ensure a coordinated approach to the administrative, operational, actuarial, and financial components of public-sponsored health care programs.

To learn more about Mercer's GHSC practice, please visit www.mercer-government.mercer.com.

At Mercer, we make a difference in the lives of more than 110 million people every day by advancing their health, wealth, and careers. We're in the business of creating more secure and rewarding futures for our clients and their employees — whether we're designing affordable health plans, assuring income for retirement or aligning workers with workforce needs. Using analysis and insights as catalysts for change, we

anticipate and understand the individual impact of business decisions, now and in the future. We see people's current and future needs through a lens of innovation, and our holistic view, specialized expertise, and deep analytical rigor underpin each and every idea and solution we offer. For more than 70 years, we've turned our insights into actions, enabling people around the globe to live, work, and retire well. We embrace a culture that celebrates and promotes the many backgrounds, heritages and perspectives of our colleagues and clients. At Mercer, we say we *Make Tomorrow, Today*. Visit www.mercer.com for more information and follow us on LinkedIn and Twitter @Mercer

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